METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

The following is a description of the policies that apply to rates and fees established for services other than inpatient hospital care, skilled and intermediate care.

Out-of-state providers are paid the same rates and fees applicable to providers in North Dakota. Medicare crossover claims will be paid based on Medicare upper limits. For services other than those involved in payment of Medicare crossover claims the state will develop a maximum allowable charge. In the absence of sufficient charge data, the state agency medical consultant will determine the reimbursement fee based on his medical judgment and background.

1) For outpatient hospital services, Medicaid pays the lower of cost or charges as determined by the Medicare intermediary, except for laboratory procedures, which are paid according to item 3 below, and dietitian services at the lower of the actual charge or maximum allowable charge established by the state agency.

2) Clinic services payment is based on the cost of delivering the services as determined by the single state agency from cost data submitted periodically by the clinic.

3) For laboratory services, Medicaid will pay the lower of actual charge, Medicare maximum allowable charge, or maximum amount established by the state agency.

   For x-ray services, Medicaid will pay the lower of actual charge or maximum amount established by the state agency.

4) For prosthetic devices, medical equipment, supplies and appliances, Medicaid will pay the lower of actual charge or allowable amount established by the state agency.

5) For physicians, podiatrists, chiropractors, and psychologists, the lower of the actual charge or maximum allowable charge established by the state agency.

6) For optometrists, dentists and dentures, Medicaid will pay the lower of actual or Medicaid fee established by the single state agency.

7) For private duty nursing, Medicaid will pay the lower of billed charges or the established fee as determined by the state agency.

8) For physical, occupational and speech therapy, payment will be the lower of billed charges or the fee established by the single state agency.

9) Glasses will be paid at the invoice price with frames not to exceed a maximum periodically determined by the state agency medical consultant.

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10) Transportation by common carrier will be reimbursed at the going rate or fare established for the general public. Ambulance services will be paid at the lower of actual billed charges or the maximum allowable charge established by the state. Private vehicles when utilized by a third party to provide transportation to a Medicaid recipient will be paid at the lower of billed charges or the mileage rate up to an upper limit periodically established by the state agency, not to exceed the mileage established by the state legislature. The payment for all meals necessary for recipients and attendants cannot exceed the amount allowed for state employees while they are traveling in the state of North Dakota. The payment for necessary lodging for recipients and attendants traveling within North Dakota cannot exceed the amount allowed for state employees. The payment for necessary lodging for recipients and attendants traveling outside of North Dakota will be limited by a maximum established by the single state agency.

11) Family planning services provided by local health departments under the auspices of the Maternal and Child Health (MCH) Division of the State Department of Health will be paid the lower of billed charge of maximum established by the MCH Division.

12) Home Health Agency services including nursing care, home health aide services, physical therapy, occupational therapy, speech pathology or audiology services, reimbursement will be at the lowest of the billed charge or maximum allowable charge established by the State.

13) For prescribed drugs, Medicaid will reimburse at the lower of 1) the provider's usual and customary charges to the general public or 2) ingredient cost (generic upper payment limit or estimated acquisition cost (EAC) of legend drugs plus a reasonable dispensing fee. Reimbursement for prescribed non-legend drugs will be the ingredient cost of the drug plus fifty percent of the ingredient cost to the dispensing fee.

    The ingredient cost for multiple source drugs identified and listed by HCFA as having generic upper payment limits will not exceed, in the aggregate, the level of payment for those drugs by an amount equal to the ingredient cost of the drug calculated according to 150 percent of the least costly therapeutic equivalent for each drug entity as identified and listed by HCFA in the Medicaid manual and subsequent revisions.

    Estimated acquisition cost (EAC) will be this agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is defined as the Average Wholesale Price (AWP) minus ten percent (10%) as determined from Blue Book on a bimonthly basis.

14) For hospice services Medicaid will pay the amounts established by HCFA at Sections 4306, 4307, and 4308 Part 4 of the State Medicaid Manual.

15) Nurse-Midwife services will be paid at the 85% level of the payment made for covered pre-natal, delivery and postpartum services provided by physicians, i.e., the lower of actual charge or 85% of the allowable amount established by the state agency for payment of physician services.

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16. Payment for Case Management Services for chronically mentally ill Medicaid recipients will be based on a fee schedule developed by the agency from annual cost reports. Reported cost data will be subject to audit by the department's provider audit unit.

17. For rural health clinic services, Medicaid pays the lower of actual charge or cost per the payment structure established by the Medicare fiscal intermediary.

18. Federally Qualified Health Centers (FQHC) will be paid a prospective rate based on their reasonable costs obtained by cost report at least every two years after receipt of the original report from FQHC's operating in the state. Such reports will be desk audited at receipt but not field audited unless irregularities are detected and establish cause for further review.

19. Certified Family Nurse Practitioners, Certified Pediatric Nurse Practitioners, and other nurse practitioners are paid at the lower of billed charges or 75% of our physician fee schedule.

20. Other Practitioner Services - For those practitioners not covered in the State Plan, payment will be based on 75% of their usual and customary billed charges.

21. Christian Science Nurses - Payment will be based on the usual and customary hourly billed charge not to exceed a maximum allowable hourly fee.

22. Christian Science Sanitoriums - Payment will be based on the rates paid by the Medicaid state agency in the state where the sanitorium is located. If no Medicaid rate has been established, payment will be based on 85% of billed charges.

23. Personal Care Services - Payments to personal care attendants will be based on the lower of billed charges or maximum allowable fees as established for qualified service providers for the Home and Community Based Care Waiver for the Elderly and Disabled.

    Payments for nursing services will be based on the usual and customary charges not to exceed a maximum allowable hourly fee.

24. Respiratory Care Services - Payments will be based on 75% of usual and customary billed charges.

25. Organ Transplants - Payments for physician services are based on Attachment 4.19-B No. 5 as described in this attachment. Payment for hospital services are based on Attachment 4.19-A.

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26. For diagnostic, screening, preventive and rehabilitative services, Medicaid will pay the lower of actual billed charges or the maximum allowable fee established by the state agency.

27. Emergency hospital services - For outpatient services if the hospital is Medicare eligible, payment would be based on the procedure outlined in paragraph 1 in Attachment 4.19-B. If the hospital does not participate in Medicare, payment will be made at 80% of billed charges.

    For inpatient services if the hospital is enrolled in a state Medicaid program, payment will be made in accordance with the method used by that state to reimburse for the service provided. If the hospital does not participate in the Medicaid program in the state where the facility is located, payment will be made at 80% of billed charges.

28. For Targeted Case Management Services for Pregnant Women and Infants, traumatic brain injury individuals, children in alternative care, children receiving child protective services, and pre and post adoption children, payment will be based on the lower of the providers actual billed charge or the fee schedule established in 15 minute units of service by the state.

29. Indian Health Service facilities or 638 Tribal facilities will be paid the encounter rate established by the Health Care Financing Administration which is published periodically in the Federal Register for established services provided in a facility that would ordinarily be covered services through the North Dakota Medicaid Program. The following services are covered by the all-inclusive rate:

Outpatient	Mental Health (Psychiatrist/Psychologist)
Pharmacy	EPSDT
Vision	Telemedicine-Clinic/Physician
Dental	Telemedicine-Mental Health Services